DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155726	A. BUILDING 01 B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS AT RIVER TERRACE ESTATES	400 CAYLOR BLVD BLUFFTON, IN 46714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/17/11 Facility Number: 003575 Provider Number: 155726 AIM Number: 200395060 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Woodlands at River Terrace Estates was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 30 and had a census of 26 at the time of this survey. Addendum Approved 3/21/11 DA Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/24/11. DA The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:	K 000	**K000** **The submission of this plan of correction does not constitute as admission by the provider of any fact or conclusion set forth in this statement of deficiency. This plan of correction is submitted because the law requires it.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	3-9-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APPROVED
3/21/11 DA

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K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 pairs of doors protecting corridor openings for the Healthcare activity room were smoke resistant. This deficient practice could affect all residents in the activity room and the main dining room. Findings include: Based on an observation with the Maintenance Supervisor on 02/17/11 at 12:01 p.m., there was a gap one half inch wide gap between the decorative double corridor doors entering the Health Care activity room when closed which	K 018	**K018** **IDR** see addendum	

Add'm

River Terrace
ESTATES

March 11, 2011

River Terrace Estates
100 Caylor Blvd.
Bluffton Indiana 46714

Addendum: Plan of Correction 2011

Mr. Austill

Below is the follow up to the K018 tag for our LSC 2011 Survey.

1.) The ½" gap on the Heathcare activity room doors was repaired with astragal strips on both sets of doors into activity room on March 11, 2011. A smoke detector is scheduled for installation in the activity room for March 15, 2011.

2.) All residents have the potential to be affected by the deficient practice.

3.) An in-service was conducted with all staff on March 11, 2011 regarding the ½" gap in any smoke door (NFPA 101 section 19.3.6.3.6.) (See Attachment V)

4.) Plant Operations Director/Designee will audit all remaining doors in the Healthcare area. The results will be reported annually to the QA Committee. (See Attachment X)

5.) Date of compliance March 19, 2011.

Sincerely

Daryl Elliott
Plant Operations Director
Office Line 260-353-3910

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K 018	Continued From page 2 would not resist the passage of smoke. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 penetrations caused by the passage of wire and/or conduit through the smoke barrier wall were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the	K 025	**K025** **(1.)** The unsealed 1 inch hole around a flexible conduit in the drop down smoke barrier wall was caulked on February 17, 2011. The 5x8 inch hole located above the drop down ceiling was patched on March 2, 2011. (See attachment A) **(2.)** All residents have the potential to be affected by the deficient practice. **(3.)** An in-service was conducted with all maintenance staff on March 11, 2011 regarding the new policy for inspection of smoke barrier walls. (See attachment B and C) **(4.)** Plant Operations Director/ Designee will monitor all installations or any penetrations made through any existing smoke barrier wall through the use of a contractor checklist sheet. The results will be reported to the QA Committee. (See attachment D) **(5.)** Date of compliance March 19, 2011	

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K 025	Continued From page 3 specific purpose. This deficient practice could affect both smoke compartments and therefore all 26 residents. Findings include: Based on observation with Maintenance Supervisor on 02/17/11 at 12:10 p.m., there was an unsealed one inch hole around flexible conduit in the smoke barrier wall above the drop down ceiling. Additionally, in the ceiling at the smoke barrier wall there was a eight inch by five inch section where one of two layers of drywall had been removed and not replaced. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K 025		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.	K 050	**K050** **(1.)** Plant Operations Director/ Designee has implemented a new fire drill schedule to include fire drills per shift per month. (See attachment E) **(2.)** All residents have the potential to be affected by the deficient practice. **(3.)** An in-service was conducted with maintenance staff on new monthly fire drill schedule. (See attachment F) **(4.)** Plant Operations Director/ Designee will monitor monthly fire drills one time each month for one year. The results will be reported to the QA Committee. (See attachment G) **(5.)** Date of compliance March 19, 2011.	

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K 050	Continued From page 4 Findings include: Based on review of the "Monthly Fire Drill Activation Form" with the Maintenance Supervisor on 02/17/11 at 10:33 a.m., there was no record of a third shift fire drill for the second quarter of 2010. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b) 3.1-51(c)	K 050		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure complete automatic sprinkler coverage was provided for 2 of 2 electrical closets in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide	K 056	**K056** **(1.)** On March 7, 2011 the sprinkler heads were installed in the electrical rooms. (See attachment H) **(2.)** All residents have the potential to be affected by the deficient practice. **(3.)** An in-service was conducted with maintenance staff on the sprinkler regulations of K-056. (See attachment I) **(4.)** Plant Operation Director/ Designee will audit all remaining storage and electrical areas of healthcare. The results will be reported to the QA Committee. (See attachment J) **(5.)** Date of compliance March 19, 2011.	

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K 056	Continued From page 5 complete coverage for all portions of the building. NFPA 13, 5-13.11, Exception: Sprinklers shall not be required where all of the following conditions are met: (a) The room is dedicated to electrical equipment only. (b) Only dry-type electrical equipment is used. (c) Equipment is installed in a 2-hour fire-rated enclosure including protection for penetrations. (d) No combustible storage is permitted to be stored in the room. This deficient practice could affect all 22 residents in the Long hall and any resident in the Physical Therapy room in the event of an emergency. Findings include: Based on observations with the Maintenance Supervisor on 02/17/11 from 11:45 a.m. to 11:50 a.m., the electrical closets in the Physical Therapy room and the Long hall lacked sprinkler coverage. This was acknowledged by the Maintenance Supervisor at the time of observations. 3.1-19(b)	K 056	**K069** **(1.)** A stainless steel panel was installed on the side of deep fat fryer on March 7, 2011 (See attachment K) **(2.)** All residents have the potential to be affected by the deficient practice. **(3.)** An in-service was conducted with maintenance and kitchen staff on fryer safety on March 11, 2011. (See attachment L) **(4.)** Plant Operations Director/ Designee will monitor all open flame kitchen equipment monthly for three month and annually thereafter. The results will be reported to the QA Committee. (See attachment M) **(5.)** Date of compliance March 19, 2011.	
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install and maintain 1 of 1 kitchen hood fire suppression systems as required. NFPA 96, 9-1.2.3 requires deep fat fryers be installed at least 16 inches from the surface flames of adjacent cooking equipment or have a protective shielding constructed of steel or tempered glass measuring at least eight inches in height between	K 069		

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K 069	Continued From page 6 the two appliances. This deficient practice was not in a resident care area but could affect all kitchen staff in the event of an emergency. Findings include: Based on an observation with the Maintenance Supervisor on 02/17/11 at 11:20 a.m., the deep fat fryer was located five inches from the open flame grill and did not have a protective shield measuring at least eight inches in height between the two appliances. Measurements were provided by the Maintenance Supervisor at the of observation.	K 069		
K 070 SS=E	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have a policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect all residents in or near the Medical Records office located adjacent the nurses' station in the event of an emergency. Findings include: Based on an observation with the Maintenance	K 070	**K070** **(1.)** The policy for space heaters was effective since 2009, but when the surveyor was here we were unable to locate the policy. (See attachment N) **(2.)** All residents have the potential to be affected by the deficient practice. **(3.)** An in-service was conducted with all staff on March 11, 2011 regarding the policy about the use of space heaters. (See attachment O) **(4.)**Plant Operations Director/ Designee will monitor the use of space heaters weekly for three weeks and quarterly thereafter. The results will be reported to the QA Committee. (See attachments P & Q) **(5.)** Date of compliance March 19, 2011	

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K 070	Continued From page 7 Supervisor on 02/17/11 at 11:35 a.m., there was an oil filled space heater sitting in the Medical Records office. The space heater was not in use at this time. Based on interview with the Maintenance Supervisor on 02/17/11 at 11:10 a.m., the facility did not allow space heaters and did not have a policy regarding the use of space heaters in the facility. 3.1-19(b)	K 070		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquifed petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas	K 144	**K144** **(1.)** Plant Operations Director contacted NIPSCO, the gas supplier, to update the required letter of compliance. The letter was received on March 1, 2011. (See attachment R) **(2.)** All residents have the potential to be affected by the deficient practice. **(3.)** An in-service was conducted with maintenance staff on requirements for gas reliablity letter per CMS. (See attachment S) **(4.)** Plant Operations Director/ Designee will monitor that the letter is current. The results will be reported to the QA Committee. (See attachment T) **(5.)** Date of compliance March 19, 2011.	

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K 144	Continued From page 8 Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all occupants. Findings include: Based on interview with the Maintenance Supervisor on 02/17/11 at 11:15 a.m. , the fuel source for the emergency generator was natural gas. Additionally, based on review, the facility did have a letter from their natural gas provider (NIPSCO) dated December 14, 2009 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter lacked supporting statements of reliability of natural gas, low probability of interruption of the	K 144		

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K 144	Continued From page 9 natural gas service and a signature of a technical person. This was acknowledged by the Maintenance Supervisor during the time of record review. 3.1-19(b)	K 144		